I Studied Five Countries' Health Care Systems. We Need to Get More Creative With Ours.

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By Aaron E. Carroll

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Despite just experiencing a pandemic in which over one million Americans died, health care reform doesn't seem to be a top political issue in the United States right now. That's a mistake. The American health care system is broken. We are one of the few developed countries that does not have universal coverage. We spend an extraordinary amount on health care, far more than anyone else. And our broad outcomes are middling at best.

When we do pay attention to this issue, our debates are profoundly unproductive. Discussions of reform here in the United States seem to focus on two options: Either we maintain the status quo of what we consider a "private" system, or we move toward a single-payer system like Canada's. That's always been an odd choice to me because true single-payer systems like that one are relatively rare in the world, and Canada performs almost as poorly as we do in many international rankings.

Moreover, no one has a system quite as complicated as ours.

A more productive debate might benefit from looking around the world at other options. Many people resist such arguments, however. They think that our system is somehow part of America's DNA, something that grew from the Constitution or the founding fathers. Others believe that the health care systems in different countries couldn't work here because of our system's size.

I think those are bad excuses. Our employer-based insurance system is the way it is because of World War II wage freezes and I.R.S. tax policy, not the will of the founders. And much of health care is regulated at the state level, so our size isn't really an outlier. We could change things if we wanted to.

In the first half of the year, I was privileged to visit five other countries and learn about their health care systems. In February I traveled to Britain and France with Indiana University's Kelley School of Business, and more recently, with the Commonwealth Fund and AcademyHealth, to New Zealand, Australia and Singapore.

Australia and New Zealand are two other countries with single-payer systems out there, although their systems differ greatly from that of Canada and from each other's. Unlike our neighbor to the north, they allow private insurance for most care, which can be applied to pay for faster access with more bells and whistles. In addition, Australia's system has fairly high out-of-pocket payments, in the form of deductibles and co-pays.

France's system is close to a single-payer one because almost everyone gets insurance from one of a few collective funds, mostly determined by employment or life situations. They also have out-of-pocket payments and expect most people to pay upfront for outpatient care, to be reimbursed later by insurance. That's something even the United States system doesn't do.

Britain, on the other hand, has no out-of-pocket payments for almost all care. Private insurance is optional, as it is in other countries, to pay for care that may come faster and with more amenities. Relatively few people purchase it, though.

As I've written about before, Singapore has a completely different model. It relies on individuals' personal spending more than almost any other developed country in the world, with insurance only really available for catastrophic coverage, or for access to a private system that, again, relatively few use.

America could learn a thing or two from these other countries. We could take inspiration from them and potentially improve access, quality and cost. However, it's important to frame our examination correctly. Focusing on these countries' differences misses the point. It's what they have in common — and what we lack — that likely explains why they often achieve better outcomes than we do.

Universal coverage matters, not how we get there.

The pandemic should have been an eye-opener in terms of how much work we need to do to repair the cracks in our health care foundation. Unfortunately, we seem to have moved on without enough focus on where we fall short and what we might do about it. It's outrageous that the health care system hasn't been a significant issue in the 2024 presidential race so far.

Even if we did have that national conversation, I fear we'd be arguing about the wrong things. We have spent the last several decades fighting about health insurance coverage. It's what animated the discussions of reform in the 1990s. It's what led to the Affordable Care Act more than a decade ago. It's what we are still arguing about. The only thing we seem able to focus on concerns insurance — who provides it, and who gets it.

No other country I've visited has these debates the way we do. Insurance is really just about moving money around. It's the least important part of the health care system.

Universal coverage matters. What doesn't is how you provide that coverage, whether it's a fully socialized National Health Service, modified single-payer schemes, regulated nonprofit insurance or private health savings accounts. All of the countries I visited have some sort of mechanism that provides everyone coverage in an easily explained and uniform way. That allows them to focus on other, more important aspects of health care.

Only the United States can't decide on a universal coverage scheme, and not only does it leave too many people uninsured and underinsured, it also distracts us from doing anything else. We have all types of coverage schemes, from veteran's affairs to Medicare, the Obamacare exchanges and employer-based health insurance, and when put together they don't work well. They're all too complicated, too inefficient and fail to achieve the goal of universal coverage. Our complexity, and the administrative inefficiency that comes with it, is holding us back.

When I was younger, I was more of a single-payer advocate, until I realized how many systems perform better than Canada's. More recently, I favored the tightly regulated, entirely private insurance system of Switzerland because it performs exceptionally well using a private scheme I thought would be more palatable to many Americans. Today, though, I really don't care how we get to universal coverage.

If we could agree on a simpler scheme — any one of them — we could start to focus on what matters: the delivery of health services.

Public delivery systems are essential, but so are private options.

What separates the countries I traveled to from the United States is that they largely depend on public delivery systems. Most people get their hospital care from a government-run facility. However, each country also has a private system that serves as a release valve. If people don't like the public system, they can choose to pay more, either directly or indirectly, through voluntary private health insurance, to get care in a different system.

The care delivered in these public systems is often just as good, in terms of outcomes, as what is delivered in the private system. The same doctors often work in both settings. What is different is the speediness of care and the amenities that come with it. If you choose to get care in a public system, you often have to wait in line. Most often, the wait doesn't lead to worse outcomes, and people accept it because it's much cheaper than paying for private hospital care. Those who don't want to wait, or feel they can't, can pay more to jump the queue.

In fact, explicit tiering is a feature, not a bug, of all of these other systems. Those who want more can get more, even in Singapore's public system. But "more" isn't better care; it's more choice in terms of physicians, private rooms, fancier food and even air conditioning. (While many Americans see the latter as a necessity, most people in Singapore — where it's much hotter — don't agree.)

In the United States, on the other hand, most care is provided by private hospitals, either for-profit or nonprofit. Even nonprofit systems compete for revenue, and they do so by providing more amenity-laden care. This competition for more patient volume leads to higher prices, and

while we don't explicitly ration care, we do so indirectly by requiring deductibles and co-pays, forcing many to avoid care because of cost. Our focus on what pays — acute care — also leads us to ignore primary care and prevention to a larger extent.

I'm convinced that the ability to get good, if not great, care in facilities that aren't competing with one another is the main way that other countries obtain great outcomes for much less money. It also allows for more regulation and control to keep a lid on prices.

I'm not arguing it would be easy to expand the number of public hospitals in the United States. It would be politically difficult to expand the government's role in delivering health care, directly or indirectly. But allowing people to choose whether to accept cheaper care delivered by a public system or to pay more for care in a private system might make this much more palatable. By doing so, we could make sure that good care is available to all, even if better care is available to some.

Strong social policies matter.

I have been to Singapore twice now to learn about the country's health care system, and twice I've watched my hosts spend significant time showcasing their public housing apparatus. More than 80 percent of Singaporeans live in public housing, which involves more than one million flats that were built and subsidized by the government. Almost all Singaporeans own their own homes, too, even publicly subsidized ones; only about 10 percent of them rent.

Because of government subsidies, most people spend less than 25 percent of their income on housing and can choose between buying new flats at highly subsidized prices or flats available for resale on an open market.

This isn't cheap. It's possible, though, because the government is only spending about 5 percent of G.D.P. on health care. This leaves a fair amount available for other social policies, such as housing.

Other social determinants that matter include food security, access to education and even race. As part of New Zealand's reforms, its Public Health Agency, which was established less than a year ago, specifically puts a "greater emphasis on equity and the wider determinants of health such as income, education and housing." It also specifically seeks to address racism in health care, especially that which affects the Maori population.

In Australia I met with Adam Elshaug, a professor in health policy at the Melbourne School of Population and Global Health. When I asked about Australia's rather impressive health outcomes, he said that while "Australia's mortality that is amenable to, or influenced by, the health care system specifically is good, it's not fundamentally better than that seen in peer O.E.C.D. countries, the U.S. excepted. Rather, Australia's public health, social policy and living standards are more responsible for outcomes."

Addressing these issues in the United States would require significant investment, to the tune of hundreds of billions or even trillions of dollars a year. That seems impossible until you

remember that we spent more than $4.4 trillion on health care in 2022. We just don't think of social policies like housing, food and education as health care.

Other countries, on the other hand, recognize that these issues are just as important, if not more so, than hospitals, drugs and doctors. Our narrow view too often defines health care as what you get when you're sick, not what you might need to remain well.

When other countries choose to spend less on their health care systems (and it is a choice), they take the money they save and invest it in programs that benefit their citizens by improving social determinants of health. In the United States, conversely, we argue that the much less resourced programs we already have need to be cut further. The recent debt limit compromise reduces discretionary spending and makes it harder for people to access government programs like food stamps. As Mr. Elshaug noted, doing the opposite would lead to better outcomes.

We are already doing what other countries can't.

These other countries' systems are not perfect. They face aging populations, expensive new technologies and often significant wait times — just like ours does. Those problems can make some people quite unhappy, even if they're not more unhealthy.

When I asked experts in each of these countries what might improve the areas where they are deficient (for instance, the N.H.S. has been struggling quite a bit as of late), they all replied the same way: more money. Some of them lack the political will to allocate those funds. Others can't make major investments without drawing from other priorities.

Singapore might, though. With its rapidly aging population, it likely needs to spend more than the around 5 percent of G.D.P. Jeremy Lim, director of the country's Leadership Institute for Global Health Transformation and an expert on its health care system, said that while Singapore will need to spend more, it's very unlikely to go above the 8 percent to 10 percent of G.D.P. that pretty much all developed countries have historically spent.

That is, all of them except the United States. We currently spend about 18 percent of G.D.P. on health care. That's almost $12,000 per American. It's about twice what other countries currently spend.

With that much money, any of these countries could likely solve the issues it faces. But spending substantially more on health care is something they feel they cannot do. We obviously don't have that issue, but it's intolerable that we get so little for what we spend.

We cannot seem to do what other countries think is easy, while we've happily decided to do what other countries think is impossible.

But this is also what gives me hope. We've already decided to spend the money; we just need to spend it better.

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